STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Irvine Neuro Rehabilitation
Petitioner **File No. 21-1733**

v

MemberSelect Insurance Company
Respondent

Issued and entered
this 17th day of February 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On November 11, 2021 and December 8, 2021, Irvine Neuro Rehabilitation (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of MemberSelect Insurance Company (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner bill denials on October 8, 2021, and November 11 and 15, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on December 8, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on December 8, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on December 21, 2021.

The Department assigned an independent review organization (IRO) to analyze issues requiring medical knowledge or expertise relevant to this appeal. The IRO submitted its report and recommendation to the Department on January 10, 2022. The Director issued a written notice of extension to both parties on January 14, 2022.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for physical therapy treatments rendered on August 24, 26 and 30, 2021, and September 16, 21, and 28, 2021. The procedure codes at issue include 97110 and G2251, which are described as therapeutic exercise and brief communication technology-based service. In its *Explanation of Benefits* letter, the Respondent stated that the treatment "exceeds the period of care for either utilization or relatedness." The Respondent further stated that the treatment was not supported by the American College of Occupational and Environmental Medicine (ACOEM) guidelines for traumatic brain injury (TBI).

With its appeal request, the Petitioner submitted supporting documentation which identified the following diagnoses for the injured person in relation to a motor vehicle accident (MVA) that occurred in June of 2012: TBI, cervical fracture with spinal fusion, spinal cord injury, and central cord syndrome with tetraplegia. The Petitioner referenced the Centers for Medicare and Medicaid Services (CMS) and stated that therapy services provided to maintain the injured person's current condition and to slow or prevent deterioration "cannot be denied based on the absence of potential for improvement or restoration."

The Petitioner's request for an appeal stated:

> The complexity of [the injured person's] neurologic and orthopedic injuries requires ongoing skilled therapy to address deficits with balance, gait, strength, neuromuscular and cognitive function. [The injured person's] severe safety limitations due to multiple and complex injury-related deficits establish a vital need for skilled therapeutic services to reduce the risk of additional functional decline leading to increased burden of medical care.

In its reply, the Respondent reaffirmed its position and referenced ACOEM guidelines for TBI in support. The Respondent noted that the injured person attended "217 physical therapy treatment sessions" since 2019 with little to no interruption and stated that the rendered treatment exceeds the guideline recommendations of 8 weeks of physical therapy. The Respondent stated that "significant opportunity has been given to initiate and reinforce a home exercise and activity program" for the injured person.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding inappropriate treatment and overutilization.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, medical necessity was not supported on the dates of service at issue and the treatment was overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is a practicing physical therapist with knowledge of the care of individuals involved in a motor vehicle accident with chronic severe or moderately severe TBI and functional deficits. In its report, the IRO reviewer referenced R 500.61(i), which defines "medically accepted standards" as the most appropriate practice guidelines for the treatment provided. These may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, board, and associations. The IRO reviewer relied on the American Physical Therapy Association (APTA) and the American Neurological Physical Therapy Association (ANPTA) guidelines relating to TBI, as well as medical literature, for its recommendation.

The IRO reviewer explained that, according to the APTA and ANPTA guidelines, "telehealth physical therapy is not recommended for TBI patients." The IRO reviewer noted that the injured person received "significant amounts of treatment in outpatient physical therapy" for his brain injury. Regarding the dates of service at issue, the IRO reviewer indicated that the Petitioner did not document sufficient progress in the submitted records. More specifically, the IRO reviewer stated:

> [The injured person's] physical therapy treatment was not progressed in terms of frequency, resistance, or number of repetitions, was not tracked with objective measurements, and objective scores were not utilized to track his progress or decline in physical therapy.

The IRO reviewer opined that the physical therapy treatments rendered to the injured person "were routine and did not progress in intensity, frequency, or resistance." The IRO reviewer explained that even when a patient is receiving maintenance physical therapy, as in the injured person's scenario, "there has to be progression in the treatment parameters" in accordance with medically accepted standards. The IRO reviewer further stated:

> Furthermore, no objective measures were noted in [the injured person's] treatment records, and objective measurements should be made to demonstrate a patient's progress during their course of treatment. Finally, a patient's treatment interventions should be adjusted to their progress with physical therapy. In [the injured person's] physical therapy treatment notes, there was no documentation that his treatment was adjusted to a changing condition or progress of his scenario.

The IRO reviewer recommended that the Director uphold the Respondent's determination that the physical therapy treatment provided to the injured person on August 24, 26 and 30, 2021, and September 16, 21, and 28, 2021 were not medically necessary in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determinations dated October 8, 2021, and November 11 and 15, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford